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W 00	INITIAL COMMENT	s	W 000		,	+	
	through March 22, 2 four clients was sele of eight clients with	ay and death investigation ducted from March 20, 2007 007. A random sample of acted from a client population varying degrees of disabilities. It was the designated as the urvey.		<u></u>			
	health and safety, the examine the Condition	ated using the fundamental e to concerns in the area of e survey was extended to on of Participation in Active otection and Health Care		· .			
	management, and a	roup home and three day ith direct care staff and review of the habilitation and s to include the unusual	·				
N 104	Client #5 that occurre results of the investig interviews with the Quarter Professional (QMRP)	Jalified Mental Retardation , the home manager, two Sociates, nursing staff (1 of Nursing (DON) In edical and habilitation ed.	W 104				
	The governing body model to budget, and operating	nust exercise general policy, direction over the facility.					
RATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNAT	PIIĐE				
	tymes	Stroke		Preside	1	X6) DATE	
deficiency r safeguar ving the d following	statement ending with an ards provide sufficient protect ate of survey whether or not the date these documents is	isterisk (*) denotes a deficiency which ion to the patients. (See Instructions.) is plan of correction is provided. For rare made available to the facility. If define the control of the facility is defined as a second of the facility.	the institution m Except for nurs nursing homes, to	ay be excused from correcting p	roviding it is determ	#/30/ nined that le 90 days paable 14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/05/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. (X3) DATE SURVEY A BUILDING COMPLETED B. WING 09G057 NAME OF PROVIDER OR SUPPLIER 03/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 426 "Q" STREET, NW WASHINGTON, DC 20001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX מו PREFIX (X5) COMPLETION TAG TAG DEFICIENCY) W 104 Continued From page 1 W 104 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body failed to provide general operating direction over outside services: The findings include: 1. The Governing Body failed-to ensure that agency personnel had been trained on the implementation Medical Emergency Policy and Please see answer to W122, W149, Procedures. [See W122, W149, W318, W322 W318, W322 and W 331. and W3311 2. The Governing Body failed to have an effective system to ensure that Client #5 personal property An inventory was conducted on 3-23-67 was inventoried as outlined in the agency's Death 03/23/0 and all the items were secured Policy and Procedures. [See W137] safely. 3. The governing Body failed to ensure that contract pest control services were effective and Please see answer to W 454 assisted in providings a sanitary environment. [See W454] W 122 483.420 CLIENT PROTECTIONS W 122 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews, it was demonstrated that the failed to document having informed each client, or surrogate healthcare decision-maker as

appropriate, the risks associated with taking controlled medications and the right to refuse treatment [W124]; failed to ensure personal

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/05/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G057 NAME OF PROVIDER OR SUPPLIER 03/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 426 "Q" STREET, NW WASHINGTON, DC 20001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 122 Continued From page 2 W 122 property was secured after the death one of the clients residing in the facility as described in the agency's policy and procedures [See W137]; failed to implement establish written policy to clearly address incident management, injuries of known and unknown and ;facility falled to document prompt notification of parents or guardians of significant incidents or change in health status [See W148]; failed to ensure that medical personnel were notified for each clients' health and safety [See W149]; facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator[See W153]; failed to ensure that all injuries of unknown origin were thoroughly investigated [See W154]; facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety [See W159], failed Please see answer to W124, W137, to ensure that each employee had been provided with adequate training that enables the W148, W149, W 153, W154, W 159 employees to perform his or her duties [See and W189. W1891. The findings of these systemic practices results in the facility's failure to adequately govern the facility in a manner that would ensure that its clients' rights to be protected from potentially

FORM CMS-2567(02-99) Previous Versions Obsolete

harmful.

RIGHTS

483.420(a)(2) PROTECTION OF CLIENTS

The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

W 124

Event ID: W8IP11

Facility ID: 09G057

W 124

If continuation sheet Page 3 of 40

Statemen	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LULTIPLE CONSTRUCTION	(X3) DATE	O. 0938-03 SURVEY PLETED
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W 124	Continued From pa	ge 3	W 1			
	Based on observation review, the facility for informed each client decision-maker as a associated with taking the right to refuse the clients in the sample. The finding includes 1. Review of Client 2, 2006 at approximation the client was given an audiological example evidence that written obtained for the use. 2. The evening med on March 20, 2007 and Zyprexa 2.5 mg. The client receives this methaviors to include record verification proon the client received that the client received day for his maladaptic. On March 21, 2007, record failed to show informed consent has of the medication. The potential risks invited the client received the consent has of the medication, or his rigulation of the medication or his rigulation.	#2's medical record on June ately 2:30 PM revealed that Ativan 3 mg as a sedation for nination. There was no informed consent was of sedation. Ilication pass was observed at 5:15 PM, Client #4 received a nurse indicated that the nedication for his maladaptive aggression. During the ocess, it was confirmed by ilan order dated March 2007, ad Zyprexa 2.5 mg twice a ve behaviors. further review of Client #4's avidence that written deen obtained for the use here was no evidence that olved in using this ht to refuse treatment had	۱۰	Client # 2's written consobtained prior to audiolo examination [Please see consent form.] Attach, Client receives the said m his maladaptive behaviors aggression. Which is an emaintenance doze for client A consent for psychotropic administration was obtained by which already exrisks and benefits of treatm (Please see attachment)	edication for including stablished at # 4. comedication ad for client # plains the nent.	2/22/07

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W 124	Continued From pa	ge 4	W 1	24			
	2006, indicated the tested in the severe	client's cognitive abilities range of retardation and he to process information		24			
W 137	facility failed to docu appropriate surroga W263]	d assessed the client as not aking informed decisions, the iment attempts to secure an te decision-maker. [See	W 1	37	Client # 4/sister the legal guardian and surrogar decision maker appointed by the (See court report) C 1 to C 2	he court	
	have the right to reta personal possession	•					
	failed to ensure persafter the death one of			_ [¹	DCHC had a detailed meet Client # 5's sister on 03/ 2:00PM. At that time. The	12/07 at	ĺ
	Assurance Coordinat 11:00 PM, did not rev prepared a personal Client #5's death. Review of the records these conversations!	ector and the Quality for on March 22, 2007 at realed that the agency property inventory after as did not evidence that any of had been documented to n of the client personal		l l t t	discussion was funeral arranger Personal property, personal fir # 5. At the request of the far have to defer the discussion A personal property for another their choosing. The sister was a meeting on 04/18/07. She told us to donate all his proper 5. She and her family was ver	nents, nances of mily- we about his day of called for verbally ty to DC	
				1.3	with the funeral arrangements	- 443	i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 148	Review of the agent Policy" in the "Dispoincluded the followin" "An inventory of fur by the residential probing notified of the beaccessible to the manager. Every on disposition of the protelevision, furniture, be forwarded to the Government through 483.420(c)(6) COMI CLIENTS, PARENT The facility must not parents or guardian changes in the clients.	cy's "Death of a Resident sition of Property" section ag: ads and property will be taken ogram five (5) working days of death. This information will a family, guardians, and Case is jointly determine the final operty such as clothing, etc. Balance of finances will District of Columbia in the Case Manager." MUNICATION WITH S & ify promptly the client's of any significant incidents, or its condition including, but not ness, accident, death abuse	W 137	DCHC has amended our accommodate personal space such bereavement which in 30 days instead of 5. (Please see attachment) D	e following ow reflects	, <i>*+-1-</i> 07-
	Based on interview a failed to document p or guardians of signi health status, for one sample. (Client #4) The finding includes: Interview with the QA #4's medical record r progress note dated described Client #4 v upper lip. Treatment provided until March	not met as evidenced by: and record review, the facility rompt notification of parents ficant incidents or change in a of the four clients in the MRP and Review of Client revealed a physician's March 2, 2007. The note with two abrasions on his and follow-up care were not 5, 2007. On March 20; 2007 D AM, during the entrance	·]	QMRP was in-serviced on repunusual incidents based on the DDS's office of investigation compliance unit policy on 04-0 DCHC Incident Management Investigator. (See the attached sign in sheet policy). $\Theta - \Theta$ 15	and 03-07 by	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/05/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED B. WING 09G057 03/22/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 426 "Q" STREET, NW WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) W 148 Continued From page 6 W 148 conference, the Qualified Mental Retardation Professional (QMRP) indicated the client had a legal guardian and who was very involved in his habilitation and care. Review of the incident report revealed that the guardian/family members were not notified of this injury. The QMRP further indicated that notification of guardians/family members are document on incident reports. W 149 483.420(d)(1) STAFF TREATMENT OF W 149 CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that direct care staff implemented the agencies policy and procedure on reporting medical situations to medical personnel on of the client who resided in the facility to ensure prevention and safety. The finding includes: Interviews with the House Manager (HM), the direct care staff, medication nurse and the Director of Nursing (DON) and review of client #5's medical records and the facility's direct care staff communication log on March 20 and 21, 2007 provided evidence that the facility's direct care staff failed to follow their policy of reporting health changes to the appropriate medical personnel as evidenced by the following: a) Interview with the House Manager (HM) on March 20, 2007 at 12:15 PM revealed that on March 11, 2007 between 7 PM and 8 PM Client

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#5's health status coof vorniting and diar HM, the client who assistance with dressistance with the wear wear wear wear wear wear wear wea	hanged. He had an episode Thea and according to the Usually requires minimal Sing, had to be assisted with Ill care (taking a bath and	** 14		was done on		
communication log of client had vomited a care staff that he sh no documentation from concerns. Also there the medical/nursing client's change in he diarrhea and appare the facility's non emotive policy, medical policy, medical propositions to include	during that evening that the nd encouraged the direct ould be watched, there was om the overnight shift of any e was no documentation that staff was informed of the alth status (vomiting, nt weakness) as required by ergency policy. According to ersonnel, [DON and primary to be called for various		04/13/07 for all the staff in emergency and N medical problems & tr to document non-emergissues shift by shift. It for all staff to follow effective 04-23-07. (See attachment format	in the facility on-emergency eatment, How gency medical is mandatory this procedure	04-13-07	
decrease in activity. facility's policy was n March 11, 2007 as the personnel was not no	The HM confirmed that the ot followed on the evening of the appropriate medical					
interviewed and repo March 12, 2007 the country that bed and appeared versistance during his direct care staff further to be assisted to the light his recliner chair. He to eat breakfast with light was reported to need feeding himself, had to	rted that on the morning of client was slow getting out of ery weak as he needed personal hygiene care. The er stated that the client had living room where he sat in did not get out of the chair his peers. The client, who minimal assistance with to be fed his breakfast in his		daily communication log tool is developed for the be used to avoid any coloss. All staffs are require sheet after each shift. All be available for nursing personnel for review.	et care staff on regency policy, and gone new entire shift to communication ed to fill a log the logs will and medical	04/13/07	
	Continued From pa #5's health status of of vomiting and diar HM, the client who is assistance with dress his evening personal putting on his pajarr bed. Although the HM do communication log of client had vomited a care staff that he sh no documentation from the medical/nursing client's change in he diarrhea and appare the facility's non emet the policy, medical p care physician] must conditions to include decrease in activity. facility's policy was in March 11, 2007 as th personnel was not in in health status. b) On March 20, 200 interviewed and repo March 12, 2007 the o bed and appeared ve assistance during his direct care staff furthe to be assisted to the his recliner chair. He to eather and the was reported to need feeding himself, had the recliner by the HM. T	#5's health status changed. He had an episode of vorniting and diarrhea and according to the HM, the client who usually requires minimal assistance with dressing, had to be assisted with his evening personal care (taking a bath and putting on his pajamas) and had to be assisted to bed. Although the HM documented in the facility's communication log during that evening that the client had vomited and encouraged the direct care staff that he should be watched, there was no documentation from the overnight shift of any concerns. Also there was no documentation that the medical/nursing staff was informed of the client's change in health status (vomiting, diarrhea and apparent weakness) as required by the facility's non emergency policy. According to the policy, medical personnel, [DON and primary care physician] must be called for various conditions to include diarrhea, vomiting, sudden decrease in activity. The HM confirmed that the facility's policy was not followed on the evening of March 11, 2007 as the appropriate medical personnel was not notified of the Client's change in health status. b) On March 20, 2007 two direct care staff were interviewed and reported that on the morning of March 12, 2007 the client was slow getting out of bed and appeared very weak as he needed assistance during his personal hyglene care. The direct care staff further stated that the client had to be assisted to the living room where he sat in his recliner chair. He did not get out of the chair to eat breakfast with his peers. The client, who was reported to need minimal assistance with feeding himself, had to be fed his breakfast in his recliner by the HM. There was no documentation	Continued From page 7 #5's health status changed. 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Although the HM documented in the facility's communication log during that evening that the client had vomited and encouraged the direct care staff that he should be watched, there was no documentation from the overright shift of any concerns. Also there was no documentation that the medical/fursing staff was informed of the client's change in health status (vomiting, diarrhea and apparent weakness) as required by the facility's non emergency policy. According to the policy, medical personnel. [PON and primary care physician] must be called for various conditions to include diarrhea, vomiting, sudden decrease in activity. The HM confirmed that the facility's non emergency policy and primary care physician] must be called for various conditions to include diarrhea, vomiting, sudden decrease in activity. The HM confirmed that the facility's non-emergency policy, diarrhea and apparent weakness) as required by the facility's non-emergency policy. According to the policy, medical personnel. [PON and primary care physician] must be called for various conditions to include diarrhea, vomiting, sudden decrease in activity. The HM confirmed that the facility's policy was not followed on the evening of March 11, 2007 as the appropriate medical personnel was not notified of the Client's change in health status. b) On March 20, 2007 two direct care staff were interviewed and reported that on the morning of March 11, 2007 as the appropriate medical problems & treatment, How to document non-emergency medical issues shift by shift. It is mandatory for all staff to follow this procedure effective 04-23-07. (See attachment format for daily log & training skeet). £1, £2. An in-service training was done on 04/13/07 for all	

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	in the facility's commedical record of the in activity. There we decrease in activity medical personnel activity on March 21, PM and review of the physician's notes restaff informed the number of activity and the number of activity and the number of activity and activity and activity and activity activity. The facility must ensist activity activity. The facility must ensist activity activity activity activity activity activity activity activity. The facility must ensist activity activity activity activity activity activity activity activity. The facility activity activity activity activity activity activity activity activity activity activity. The facility activity activity activity activity activity activity activity activity. The facility activity activity activity activity activity activity activity activity activity activity. The facility activity act	munication log or the client's ne client's continuing decrease as also no evidence that the was reported to the facility's as required by the policy. I facility's medication nurse 2007 at approximately 4:00 is nursing progress notes and ported that the direct care urse on March 12, 2007 at ent was weak and had an morning. According to the right of the client's had notes the direct care staffurse of the client's had not the nurse checked is and his abdomen and ismuth 30cc, there was no surse contacted the personnel (DON or the client) concerning the changes the of the client as required by FTREATMENT OF	W 15	An in-service training was nurse on 04/03/07. All perticoncerns to be shared w PMD. [See attachment.]	s done with	04/03/07

AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE	<u>2. 0936-039</u> SURVEY LETED
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W 154	the administrator ar district law (22 DCI 3519.10) for one of (Client #4) The finding includes Review of Client #4' physician's progress The note described on his upper lip. Tre was not provided un of unknown origin w	vere reported immediately to ad other officials according to MR, Chapter 35, Section the four clients in the sample. s medical record revealed a s note dated March 2, 2007. Client #4 with two abrasions patment and follow-up care til March 5, 2007. This injury as not reported to the se State Agency as required.	W 153	See answer to W148 See answer to W148		
F F F C V S S h	This STANDARD is Based on staff interv facility falled to ensure origin were thorough four clients in the sar. The finding includes: Review of Client #4's physician's progress. The note described Con his upper lip. Treawas provided until Masturvey, there was no	not met as evidenced by: iew and record review, the re that all injuries of unknown ly investigated for one of the nple. (Client #4)		See answer to W148 See answer to W148	8	

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	PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZI 426 "Q" STREET, NW WASHINGTON, DC 20001		2/2007	
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W 154	The facility failed to above incident was origin of the injury. 483.430(a) QUALIF RETARDATION PREACH client's active integrated, coordinated qualified mental retained and observation of the facility Corofessional (QMR) monitor, integrate at health and safety.	provide evidence that the investigated to determine the IED MENTAL ROFESSIONAL treatment program must be ated and monitored by a ardation professional. Is not met as evidenced by: pon, staff interview and record dualified Mental Retardation (a), failed to adequately and coordinate each client's	W 15	4			
	property inventory we the agency's policy at the agency's policy at 2. The QMRP failed staff implemented the of notifying medical client's health status. 3. The QMRP failed staff implemented the procedure on report situations. [See W144. The QMRP failed received a continuous which includes aggress.)	I to ensure that Client #5 as completed as required by and procedures. [See W137] I to ensure that direct care be agency's medical protocol personnel in changes in each completed in changes in each personnel in changes in each complete with the facility's and agencies policy and and non emergency medical and to ensure that clients as active treatment program, assive, consistent program of specialized and		Client # 5's property done on 03/23/07. [See Please See W 13 See answer to W189. See answer to W149. See answer to W197.	enclosed convi	3/23/07	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G057	B. WING		03/22	2/2007
	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CO 426 "Q" STREET, NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	ige 11	W 15	9		
	program plan (IPP)	nd to ensure that an individual objective was developed to lentified by the interdisciplinary N227]		All the IPP programs we any discrepancies in any was revised as of 03/31/0	of the program	3-31-0 1
		ed to ensure that clients were rtunities for choice and [See W247]		Please see answer to W24	1 7.	
<u> </u>	1	ed to ensure that each client is active treatment including ins. [See W249]		Please see answer to W24	.	
W 189	Individual Program incorporated in the [See W250]	ed to ensure that each client's Plan (IPP) objectives were ir Individual activity schedules. FF TRAINING PROGRAM	W 18	Please see answer to W2.	50.	1
	initial and continuir	rovide each employee with ng training that enables the rm his or her duties effectively, npetently		•		
	Based on interview failed to ensure that provided with adeq	is not met as evidenced by: y and record review, the facility at each employee had been quate training that enables the form his or her duties effectively, petently.	·			
	The findings includ	le:				
·	were trained on the	o ensure that direct care staff e facility non-emergency protocol of notification of [See W149]		Please see answer to	W149.	

A-1-1			-			OWR NO	<u>. 0938-039</u> 1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLI	URVEY
		09G057	B. WIN	NG_		03/2	2/2007
	PROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 126 "Q" STREET, NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLÉTION DATE
W 195	The facility must en	REATMENT SERVICES Issure that specific active requirements are met.	W 1	i	Please see answer to W 140		
	Based on observation reviews, failed to enfacility are provided who has demonstratis able to function with [W197]; failed to emprogram plan (IPP) address identified in team (IDT) [W227]; provided with opport self-management [Vereincluding needed in ensure that each client received including needed in ensure that each client revises well individual activity so revise program objectives well individual activity so revise program objectives well individual activity so revise program objectives the Individual restrictive program of the client is become that restrictive program facility's HRC [W263]. The effects of these	is not met as evidenced by: ons, interviews, and record nsure clients residing in the services/care for e clients ated generally independent and with minimal/little supervision sure that an individual objectives were developed to leeds by the interdisciplinary falled to ensure clients were tunities for choice and N247]failed to ensure that if continuous active treatment terventions[W249]; failed to lent's Individual Program Plan re incorporated in their shedules [W250]; failed to lectives once the client ated [W255]; failed to review idual Program Plan (IPP) sing considered for training ctive[W258]; ; failed to ensure ams were approved by the 2]; and failed to ensure that or Intervention program, behavior modification drugs, with the written informed		:	Please see answer to W 149. An in-service training was 04/13/07 for all direct care stagoals, BSP, Data Collection treatment, Activity schedule and self management. All program were rechecked and the book as of 03-31-07. An in-service training was also direct care staff on 04/1 modified program of the individuals. [Please see attached in-service]	aff on IPP n, Active , choices the IPP placed in o done for 2/07 on identified sheet.]	H-13-07
	in the facility's failure facility in a manner t	e to adequately govern the hat would ensure its clients' atment and habilitation needs.					

PRINTED: 04/05/2007 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) keller	TIPLE CONCERNATION	<u> ДМВ NO. 0938-0</u>
AND PLAN (D PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		09G057	B. WING		
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	03/22/2007
D C HEA	LTH CARE		ŀ	426 "Q" STREET, NW WASHINGTON, DC 20001	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		
PREFIX	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LILD BE COUNTY
	Active treatment do maintain generally in able to function with absence of a contin program. This STANDARD is Based on observation of records, the facilities one client (Client #1 generally independent minimal/little supervice continuous active treatment and the need of the treatment and the is continuous active with Cliverification on March revealed that he is continuous and the serve of the treatment and the surveyor described his responding interview with the supervision. Interview with the revealed that the clie chores at his resident rash, cleaning the kings sist with planning in the surveyor of the treatment of the treatment and the clie chores at his resident rash, cleaning the kings sist with planning in the treatment of the treatme	es not include services to independent clients who are little supervision or in the uous active treatment. In not met as evidenced by: on, interview, and the review by provides services/care for who has demonstrated int and is able to function with ision in the absence of a catment programs. It is a mand activities failed to or continuos activity sed for basic activity of daily videnced below. Interview in the cord of the continuos activity and the cord of		Client # 1 is one of the individual who will be movin upon approval received from I Client #1 is employed at a gro and works 32 hours a week check biweekly. Client # 1 is not competent of make a decision according to matter and also requires assi grooming and hygiene skills. (has a program in cognitive docunt ten \$ 1 bills independent is not achieved. Also as cited is not very social on various occlient # 1 did not like to social. Any one at the program to inchange the second and ask dance while at the property of the p	g to CRF DDS. cery store and earns enough to ofinance in Client # 1 lomain to thy which client # 1 casions. ize with the Club. crease his a lady to cogram is ient# 1's serviced lection. adequate: decision es have fered to onded in desire to ith client # 1 for him
RM CMS-2567	(02-99) Previous Versions O	Daplete Event ID: WSIP11	Fe F	o move into a less restrictive rogram will be reviewed pcoming ISP on	cattin

STATEMEN	T OF DEFICIENCIES	(V1) SECRETORIES VERGO	1			OMB NO	<u>. 0938-0391</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
ı		09G0 <i>5</i> 7	e, Wi	NG_			
NAME OF I	PROVIDER OR SUPPLIER			_		03/2	2/2007
	LTH CARE			4	REET ADDRESS, CITY, STATE, ZIP CODE 26 "Q" STREET, NW		
				V	VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III D DE	(XB) COMPLETION DATE
·	2007 and Interview on March 22, 2007 very social and did is behaviors. According the enjoyed going of social/leisure recreat Interview with the care staff on March client has the skills that a desire to hand a desire to hand received a payroll of an opportunity to de instead of giving it to local banking institut surveyor and staff that y program, which once a week. Interview with Dimerch 20, 2007 at a review of the client of the client that a travet be implemented at the client that the day program him that the day follow through with the QMRP informed he did not want to atthorne would implement the condition of the program. Review of the programment of documented evidence that the IDI this program in order residential programment documented evidence documented evidence that the IDI this program in order residential programment documented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order residential programmented evidence that the IDI this program in order	with HM and direct care staff revealed that the client was not display any maladaptive g to interview with the client, at to night clubs and other ation events. The Client and with the direct 20, 2007 revealed that the to make his needs and wants appropriate choices. For informed the surveyor that he dieck bi-weekly and would like posit the check in the bank of the QMRP for deposit in the tion. He also informed the state wanted to terminate his the was scheduled to attend any Program Coordinator On approximately 11:30 Am and any program IPP revealed that all training program that was to the client stay by scheduled PPC contacted the QMRP to any program would be willing in this program but reportedly the day program that since then the day program the	W		Client # 1 has a money maprogram to count ten \$1 bills is no subsequent progress program. During a concern held at the house on 01/26/0 team had decided to continue current money management and start a banking program of forth coming ISP with a trave program and a travel train banking program is started 04/12/07.	and there in that meeting the IDT with the program during the training	પં-12- <i>0</i> 7

		T WELLOW TO DELLATORS			· · · · · · · · · · · · · · · · · · ·	OMR NO	<u>, บรรช-บรรา</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G057	a. Wii	NG _		03/22/2007	
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
DOHEA	LTH CARE				26 "Q" STREET, NW		
50112	CITTOARE				VASHINGTON, DC 20001		
(74) (0	C) HALLADY GTA	TEMENT OF DEFICIENCIES					·,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 197	Continued From pa	ae 15	w.	107			
l	•	am structure to meet his					
1	needs.	an sudcline to meet his	a.		Client #1's medication assessmen	at tool is	
i		1007			modified to 100% independence	Clima	l
	Unividual Draws	2007 review of the client's			#1 will follow a 10	э. Спеш	5-1-07
	Individual Program	Plan (IPP) dated January 2,	ļ		#1 will follow a 10 steps me	dication	
	2007 revealed obje	ectives that the client has			administration with 100% indep	endence	1
f	accomplished and	program domain that there	i		for 3 consecutive months. No	urse in-	1
Ī	was little need for to				charge will continue to monito	or (See	
Ļ	a) The client had a	self medication training			attached tool) & trahner	7. (BCC	1
	program that requir	ed the client to after set by the	ļ		amanda toot) earmonate	alem.]
	medication nurse w	ras to participate in the					!
	administration of his	s Am medication regimen.	ļ				
ŀ	Review of the data	collection sheet indicated that					j.
I	the client performed	these tasks independently.		1			į .
	b) The client had a	money management program		i			
]	to count and make	small purchases. According to	ļ				j l
	the data and staff, t	he client was able to complete	b.	_	A banking program is develo		ļ.
		inimal supervision and		`	implemental as =504/12/07 C	peu and	L1-23-07
1		client requested that he be		ĺ	implemented as of 04/12/07 for	client#I	4,70 -1
Ī	trained in how to go	to the bank and deposit his			in conjunction with his existin	g money	
l i	payroll check.	to the built and deposit his			management program.		
[Speech and Language			_ ,		ļ
	noncern to write his	s name and telephone number			attachment 'J'		
	by a model. The eli	ent refused to participate in		.			
	this program: the cal	tern refused to participate in					} [
1	una program, theres	fore, the IDT revised the	•		Client # 1 received a compute		}
,	program on July 10,	, 2006 to include the use of a			04/06/07 and revised program	m was	1
1	computer. There wa	as no evidence that the		ļ	implemented as 04/10/07. An in-	-service	1 1
	reviseo program na	d been implemented,		1	training for staff was also done		4-10-07
]	excepted on one oc	casion. Observation of the			_		7-10-07
	facility and interview	with stat ff rev revealed that			sure that program is imple		ļ.
	the client did not ha	ve a computer available for	l		properly. attachment 'k'	r	
<u> </u>	the resident in the	group home to implement this				•	[
	program.					, 1	į į
	d) The client had an	objective to increase human	Ĺ	Ì	Client #1's human sexuality obje	ective is	
	sexuality skills by as	sking a lady to dance with him.	, d.	•	not achieved. Client #1 ref	200 TR	j į
	The client attended	a night club twice a month			moderate in the	uses to	
	staff indicated that I	nis social behaviors were			participate in the program, progr		
	appropriate.				be modified during his upcom	ing ISP	1
	e) The client was de	etermined to independence in		l	and pre ISP meeting is on 05/1	4/07 to	
	personal hygiene 's	s, with the exception of wiping		ŀ	meet his need.		5-14-07
	Por por ion 1178 to 10 3	with the exception of wiping		-			

STATEMEN	T OF DEFICIENCIES	AND BEEN SEED FOR THE SECOND SEED FOR THE SECOND SE			OMB_N	<u>0. 0938-039</u> 1
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIPLE CONSTRUCTION ILDING	(X3) DATE	
		09G057	B. Wil	NG	03/	22/2007
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 428 "Q" STREET, NW WASHINGTON, DC 20001		22/2001
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 227	thoroughly following to the staff he is bei toileting. Review of needed minimal asset) The client had no gross motor. g) The client had no management. h) The client had a trained and reported responsibility for its present it at the an I objective. Is should client is not attendin required for hi job piday program person independently to his the group home resignand allow for his Indi-HM the facility transifier mis job. Additionally picked up late from the facility failed to ireinforce the client in the client for transition residential placement 483.440(c)(4) INDIVITHE individual progra objectives necessary as identified by the c	i bowel elimination. According ing verbally reminded before if the data did indicated that he sistance in this task. Itraining need in fine and intraining need in behavior training need in behavior training objective to be traveled by the group home accepted implementation and failed to DT to establish criteria for the befurther noted that the ga weekly staff meeting accement. According to the inel Client #1 could traveled job site. This would elevate consibility for transporting him ependence. According to the port him to and picks him up inally, he does not like being work.	w e, f,g	Client #1 has a travel transfective 04/06/07. Client training to use bus from he and will be picked ustaff from work. During ISP meeting on the basi program will be modified his needs if needed. (See at of program)	ining program t #1 is getting ouse to the up by the house the upcoming s of progress to better meet ttached format	04-06-07
[]	Based on observation review, the facility fail	not met as evidenced by: n, staff interview and record led to ensure that an an (IPP) objectives were				

STATEMEN AND PLAN (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S	
		09G057	B. WING_		031	10/0007
	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODI 126 "Q" STREET, NW NASHINGTON, DC 20001		22/2007
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	interdisciplinary tea assessment for two sample. (Clients #1 The findings includ 1. Interview with the Professional (QMR record revealed a Stated June 29, 200 agreed for this then goal for Client #1 to address and teleph independence for 3 2007". Further interest that the client has be the administration of Further review of the rational for implication computer to indicate the independence for implication of the retional for implication of the substitution of	ess identified needs by the am (IDT) in the comprehensive of the four clients in the and #3) es: de Qualified Mental Retardation (P) and review of habilitation (Speech Language assessment (F) in which the IDT team (F) apist to implement a program of the accomputer to type his one number with (F) consecutive months by June review with the QMRP revealed been to the main office to use computer once. de assessment revealed that ementation of the client use of ated the following: at been successful using paper of the media used will hopefully ition of this skill as well as imputer skills. Brivey, the QMRP reported that for this client to participate in the had not been purchased for a QMRP and review of the revealed that he was the in a self-medication lish the following task:	W 227	Client #1 received a compto 04/06/07. A program session was done by the speech patho Client #1 will receive staff as: complete the task. An in-service for staff was also done on the to ensure proper implementate IPP objective. Please See	of training logist. sistance to ce training same day ion of the	4-6-07
	a. Pick up the pack	age of medicine				

STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G057	B. Wii	NG_			24/55.24
į.	PROVIDER OR SUPPLIER		* · · · · · · · · · · · · · · · · · · ·	4	REET ADDRESS, CITY, STATE, ZIP CODE 126 "Q" STREET, NW NASHINGTON, DC 20001	1 03 <i>r</i> .	22/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx ·	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	111 N OE	(X5) COMPLETION DATE
W 227	b. Pop pills from the cup c. Pour water into c d. Take medicine e. Drink water f. Put cup in trash Review of the programme the objective criteries #1's participation of the supplementation of the supplementation and put	e package into the medicine cup am data sheet failed to define to determine level of Client d time period of his objective. to develop Client #3's meal ting the dinnerware away after dicated in the comprehensive	W 2	·	Client #1's medication assessment modified to 100% independence #1 will follow a 10 steps me administration with 100% independence for 3 consecutive months. No charge will continue to monite attached tool)	c. Client dication endence urse in-	5/1/07
	certified food handle 2007 at approximate Client #3 does not p preparation. Review Therapist Assessme revealed a program client] should assist weekly with verbal crecord per month for However, there was program objective wof the survey.	direct care staff and the er's personnel on March 21, sely 4:00 PM revealed that articipate in any meal of Client #3's Occupational and dated January 22, 2007 objective that stated, "[the in meal preparation twice use on 95% of the trials three consecutive months", no evidence that this as implemented at the time	3.		An in-service training was do 04/06/07 for all direct care s ensure that all the programs are for throughly. All program objective checked and all the skills docume was checked to ensure that a programs are running without complications.	taff to llowed s were ntation	4/6/07
	The individual progra opportunities for clies self-management.	DIVIDUAL PROGRAM PLAN Im plan must include at choice and	W 24	47			,
	This STANDARD is Based on observatio	not met as evidenced by: n, interview, and record					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	-1111		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		· ·	A. BÜII	LDING	·		,
		09G057	B. WIN	IG_		03/2	2/2007
	ROVIDER OR SUPPLIER			42	EET ADDRESS, CITY, STATE, ZIP CODE 16 "Q" STREET, NW ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 247	review, the facility for provided with oppoself-management for sample. (Cllent #1) The finding include the facility failed to opportunity to make additional skill for not additional skill for not linearized that he has grocery store and to was also able to defurther indicated that he has grocery store and to was also able to defurther indicated that he was also able to defurther and client information. Review of the habil March 22, 2007 at to provide information and skall 440(d)(1) PRO As soon as the interformulated a client each client must retreatment program interventions and sand frequency to sa	ailed to ensure clients were rtunities for choice and or one of the four clients in the)	W2		Client #1 is currently on a procount ten (10) \$ 1.00 bills. He program independently. To al more towards independence and of his finances, Client #1 provided supports to execute making a bank deposit.	does not low him d control will be	4)12/04

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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Ĺ	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 28 "Q" STREET, NW VASHINGTON, DC 20001		<u>2/2007</u> .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	LTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 249	Continued From pa	ge 20	w:	249		· · · · · · · · · · · · · · · · · · ·	
	Based on observati review, the facility for received continuous						
	[Cross reference the House Manage Coordinator, Client	e W197] According to QMRP, r and the Day Program #1's Individual Program Plan i implemented that included	1- a		Please see answers to W 197		
	a. The client will be and follow up service	provided with Job coaching ces.			,		
	b. The client will pa activities.	rticipate in community-based					
	c. The client will par travel-training.	rticipate in supervised				:	
·	2. The facility failed participate in his incobjectives.	to allow Client #2 to dependent living skills program				•	
	2007 at 5:42 PM, the observed to wipe Constituting wipe. The preparing the medic water and handed thank water and he constitution.	on observation on March 20, the medication nurse was lient #2's hands with a see nurse was further observe cation, pouring the clients the client the cup of medication complied with the nurse's is medication. Interview with					

		S MEDICAID SEKAICES	· · · · · · · · · · · · · · · · · · ·			OMB NO	<u>.</u> 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NULTII ILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLI	URVEY
		09G057	B. WI	NG_		03/2	2/2007
!	PROVIDER OR SUPPLIER			42	REET ADDRESS, CITY, STATE, ZIP CODE 26 "Q" STREET, NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TÁG	DX.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	UID BE	(X5) COMPLETION DATE
W 249	a self medication produced January 20, 2 objective which state the steps of the adr. The steps for the cladministered by the	se revealed that Client #2 has rogram. Review of the IPP 2007 revealed a program ted, "[the client] will complete ministration of self medication". ient to completed were	2 - a	249	An in-service training was don nurse on duty on 04/07, to ensure medication administration and make sure that clients do learnore independence. "Afrach,	also to	4/3)07
	observed finishing I The client was getti table with cookie or direct care staff was crumbs from Client dated January 20, 2 objective which stat napkin to wipe his r	nis afternoon snack of cookies. Ing up from the dining room umbs around his mouth. The s observed wiping the cookie #2 mouth. Review of IPP 2007 revealed a program red, "[the client] will utilize mouth with verbal prompting recorded per month for three	2. b	••	An in-service training was 04/13/07 to retain staff in IPP and implementation of each in program.	objective	4/13/07
	a. On March 20, 20 observed pointing to direct care staff rep the bathroom." b. On March 20, 20 Client #2 was obser afternoon snack. The client, "say than IPP dated January a program objective was an AAC device going to the bathroom and will you dance we have the communication of the communication."	I to utilize Client #2's adaptive ice as recommended by the am (IDT). DO7 at 8:15 AM, Client #2 was a the bathroom door. The lied, "Do you have to go the DO7 at approximately 4:35 PM, ved being offered an The direct care staff stated to k you." According to the client 20, 2007, the client had a which stated, "[the client] will to express a message (I'm om, thank you for the snack, with me please) on three of sions for three consecutive		eb.	An in-service training was 04/13/07. Client #2's a communication device will be k activity area and QMRP will en staff are retrained to ensure implementation.	daptive ept in the	भ् (३/० 7

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-	•	09G057	B. WIN	G		03/22/2007	
	ROVIDER OR SUPPLIER			426	ET ADDRESS, CITY, STATE, ZIP CODE B "Q" STREET, NW ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE
W 249	adaptive device wa not in the program should be noted the client was not obse communication device. 4. The facility faile participate in activity. On March 20, 2007 meal, Client #3 was room table for both Interview with the client did not be preparation. The client did not he preparation. The client plate to the Review of IPP data a program objective set the table with view of the client did not be reparation.	DMRP revealed that the is kept in the client bedroom area for the client's use. It at during the entire survey, the inved using the adaptive vice. If to allow Client #3 to the set of daily living skills. If prior to snack and dinner is observed setting the dining is snack and the dinner meal. It is care staff indicated that all or participate in meal elient was observed taking his kitchen sink after all meals. The dining is snack and the dinner meal elient was observed taking his kitchen sink after all meals. The dining is recorded per month for three is recorded per month for three	W 2	249	An in-service training was of 04/05/07 for all direct care ensure proper implementation of programs.	staff to	4/5/07
	Client #3's meal pr dinnerware away a	d to develop and implement eparation and putting the fter being washed as indicated ive functional assessment.	5.		All IPP objective were reviewed in place as of 04/01/07.	d and put	4/1/07
	certified food hand 2007 at approxima Client #3 does not preparation. Revie Therapist Assessn revealed program client] should assis	ne direct care staff and the ler's personnel on March 21, tely 4:00 PM revealed that participate in any meal w of Client #3's Occupational nent dated January 22, 2007 objective that stated. "[the tt in meal preparation twice cues on 95% of the trials	વ		Client #3 does not have a procook meal but Client #3 does kitchen twice a week. Staffs serviced for proper implementa	help in were in-	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		. 09G057	B. WING			03/22/2007	
	ROVIDER OR SUPPLIER			4:	REET ADDRESS, CITY, STATE, ZIP CODE 26 "Q" STREET, NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 249	record per month for At no time during the observed being important observed being important of the control of	or three consecutive months". se survey was this objective olemented. March 20, 2007 after er meal and afternoon snacks ofts and staff putting dishes and binets after being washed. It is occupational Therapist January 22, 2007 revealed a which stated, [the client] will exiliverware into appropriate wing washing on 95% of the onth for three consecutive eduring the survey was this being implemented. IGRAM IMPLEMENTATION evelop an active treatment are the current active treatment is readily available for review by some survey was the current active treatment.	w:) }•	All IPP objectives were revies implemented as of 04/01/07. A intraining was also held for all distaff to ensure effective implement of the programs.	n-service rect care	4/1/07
	review, the facility f client's Individual P were incorporated	ion, staff interview and record alled to ensure that each rogram Plan (IPP) objectives in their individual activity of the four clients in the	· 				
	observed participat during the AM and	s: 22, 2007, Client #1 was ing in a variety of activities PM hours. Interview with that he was employed with			·		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		09G057	B. WING		03/2	2/2007	
	ROVIDER OR SUPPLIER		4	EET ADDRESS, CITY, STATE, ZIP CODE 26 "Q" STREET, NW VASHINGTON, DC 20001	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFIGIENCY)	ULD BE .	(X5) COMPLETION DATE	
W 250	Whole Foods Groc Client #1 revealed on his days off Tue Additionally, the client attends a day programmately attends a competitively exports 40 hours over Saturday, Sunday a clients work schedule Further interview who Client #5 is off from Thursdays. Accord days the client was assignment at the competitive of the home and rechoice. Additionally Client #1 attends his treatment program. Interview with Client Day Program Coord approximately 11:1 the Client has not be According to the Coording to the Client was assignment at the coording to the Coording to the Coording to the Client #1 attends his treatment program.	ery. Further interview with that he was at the group home sday and Thursday. In a state of the s	W 250	Client #1's activity scheduler reviewed and replaced with a current IPP objectives. Client # his day program once a week a showed any interest or concert don't want to go to school. Client #1 was not feeling well for fdays which lead him to be about the day program. Also client # activity schedule for the days home. Please see attachment.	the most 1 attends and never a that he or couple sent from 1 has an he stays		
-	day, revealed that			All the activity schedules are	reviewed	4-1-07	
W 255	Client's current acti	ity schedule that reflected the vities and training programs. OGRAM MONITORING &	W 255	and revised on 04/01/07.		7-1-01	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		•	4	REET ADDRESS, CITY, STATE, ZIP CODE 26 "Q" STREET, NW VASHINGTON, DC 20001	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 255	least by the qualifier professional and rest but not limited to sit successfully comples identified in the indifferent standard in the standar	ram plan must be reviewed at dimental retardation vised as necessary, including, uations in which the client has ated an objective or objectives vidual program plan. Is not met as evidenced by: on, staff interview and record Qualified Mental Retardation P) failed to revise program client successfully completed of the four clients in the and #4)	W	255			
:	The QMRP failed Behavior Support P meet the establishe	d to revise Client #4's lan (BSP) objectives once he d criteria.	, 1	L.	Client #4's BSP objective harevised as of 05/01/07.	as been	5-1-07-
	20, 2007 at 5:25 PN being administered with the medication medication was use behaviors. Review February 22, 2007 r medications are use maladaptive behavior review of the Individ December 12, 2007 which stated, "[the cincidents of aggress months". Review of	ne medication pass on March I, Client #4 was observed Zyprexa 2.5 mg. Interview nurse revealed that the Id for his maladaptive of the client's BSP dated evealed that psychotropic ed in the BSP to address his or of aggression. Further ual Program Plan (IPP) dated revealed IPP objectives client] will maintain zero cion for 12 consecutive if the psychologist quarterly or data sheets from January	o	•	The BSP objective and data comethodology has been change 05/01/07. Currently he is on a reffective doze for optimum func	d as of	5-1-07

		- A MILDIOAD GLIVIOLG				<u>0. 0938-0</u> 391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	(X3) DATE	
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,	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 428 "Q" STREET, NW		22/2007
O(A) (D)	CURRENTY OTA	TIME AS LEGICALIA	, <u> </u>	WASHINGTON, DC 20001		
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W 255	2006 through February incidents. Additional indicated that the circumstance in the cir	ige 26 Jary 2007 revealed zero al Interview with the QMRP lient is on a maintenance opic medication, therefore	W 2	55		
	b. Review of Client 2007 revealed an o client] will identify to pointing with 50% in consecutive months of the Speech Path April 2008 through the client achieved however continue for		Ь	Even though Client #4 a established criteria, retaining ability and lev he needs consistent in speech therapist stabilization. However during the meeting the program with the	based on his el of retardation, rainings thereby requested for June 2007 IPP	6-11-07
	therapeutic recreating established criteria. Observations on Marian PM, Client #3 v	d to revise Client #3's on objective once he meet the arch 20, 2007 at approximately was observed going on a gift his housemates. Interview	2 ・	activities as stated	in recreation	
	with the direct care: approximately 6:00 participates in many outings. Review of 2006 revealed that t which stated, "[the copportunities to part activities per week a	staff on March 21, 2007 at PM, revealed that the client rhouse and community the IPP dated December 12, he client had an objective dient will be provided icipate in three to five at a rate of 75% accuracy".		objectives with staff supervision. However documenting the data wan in-service training recreational therapist QMRP & HM will mak basis to check the prope (Please see the attachm	the staff were groundly therefore g was done by on 04/13/07. the sure on weekly redocumentation.	4-13-07
W 258	the client participate as well as home act	with the QMRP confirmed that s in many community outings	W 25		, .,	5-1-07
	The individual progra	am plan must be reviewed at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G057					PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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1	PROVIDER OR SUPPLIER			47	EET ADDRESS, CITY, STATE, ZIP CODE 26 "Q" STREET, NW /ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 258	least by the qualified professional and rest but not limited to sist being considered for objectives. This STANDARD Based on observative record review, the Professional (QMR the Individual Progris being considered objective in the IPP the sample. (Client The findings included The facility's QMR Speech and Langual Interview with the Chabilitation record assessment dated for Client #1 to "Us address and telephindependence for 3 2007". Further review of the rational for recovers because: "[The Client] has not and pen. Changing enhance the acquist teach him some control of the control	ed mental retardation evised as necessary, including, tuations in which the client is or training towards new is not met as evidenced by: ions, staff interviews and Qualified Mental Retardation (P) failed to review and revise ram Plan (IPP) once the client of for training towards a new of for one of the four clients in ts #1) ie: Defailed to revise Client #1's age program objectives. QMRP and review of revealed a Speech Language June 29, 2006 a program goal of a computer to type his ione number with some number with the consecutive months by June are assessment revealed that commending that the client's use of the media used will hopefully sition of this skill as well as	W	258	Client #1's computer was purch program implementation as of 0 Orientation was given by pathologist on 04/16/07. The old program has been disco	4/10/07. speech	- 4-10-07 4-10-07 4-16-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0 9 G057	09G057 B. WING			03/22/2007	
	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 128 "Q" STREET, NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 258 W 262	indicated that Clien and pen to write his from a model. The program had been program could be in 483.440(f)(3)(i) PROCHANGE	ige consultant monthly notes t #1 continued to use paper saddress and phone number re was no evidence that this discontinued so that the new		258	· ·		
	inappropriate behaving the opinion of the client protection and the STANDARD in Based on observation review, the facility's (HRC) failed to review.	vior and other programs that, a committee, involve risks to d rights. Is not met as evidenced by: on, staff interview and record. Human Rights Committee ew and approve the use of s, for one of the four clients in t#2)					
W 263	and interviews with Retardation Profess there was no evider approved the use of audiological medica 483.440(f)(3)(ii) PR CHANGE The committee sho are conducted only	, review of the HRC minutes the Qualified Mental sional (QMRP) revealed the nce that the HRC had f Client #2's Ativan for an al consult. [See W124] OGRAM MONITORING & uld insure that these programs with the written informed t, parents (if the client is a dian.	w :	263	Please see answers to W 124	(Page 4)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G057		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE			i	4	REET ADDRESS, CITY, STATE, ZIP COD 126 "Q" STREET, NW WASHINGTON, DC 20001		
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W 263	Based on observative review the facility from the facility from the facility from the facility from the facility written informed consumple. (Client #4) The finding include the facility was no evidence on the use measures that was	is not met as evidenced by: ion, interview and record ailed to ensure program which ive techniques and use of on were conducted only with insent of the client, or legal the four clients in the the 4) s: ence of written informed of Client #4's restrictive included in the Client's	W	263	Please see the answer to W	124	
W 316	must be gradually t	RUG USAGE strol of inappropriate behavior withdrawn at least annually.	W :	316			
	Based on observat and record review, medications used to behavior had been	is not met as evidenced by: ion, client and staff interview the facility failed to ensure that or control of inappropriate gradually withdrawn at least the four clients in the sample.			·		
	observed being add Interview with the r Qualified Mental Ru that the medication maladaptive behav	s: ' at 5:25 PM, Client #4 was ministered Zyprexa 2.5 mg. nedication nurse and the etardation (QMRP) indicated s were used for his iors. Further interview with the of the Behavior Support Plan					

OCITICIO I DICINICO OL		A MEDICAL SELVAIORO				OWR NO	<u> </u>
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G057	B. WING			03/2	2/2007
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D C HEA	LTH CARE				26 "Q" STREET, NW		
240.12	CUMMARY CTA	TELESIT OF PERIODE	· .	¥	YASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 316	(BSP) on March 21 #4's BSP addresse Record verification 2007 indicated that behavior was includ (property destructio cause harm. The aforementioned bei maintain zero incide consecutive months sheets and the Psy from January 2008 revealed that the cli targeted maladaption There was no evide addressed a reduct medications as the management criteri	a, 2006 indicated that Client d aggression. of the BSP dated February 22, the following maladaptive ded in the BSP: aggression on picking up objects that objectives for the havior stated, "[the client] will ents of aggression for 12 as. According to the data chologist quarterly reviews through February 2007 ient had not displayed the re behaviors. Ince that the client's IDT had ion in psychotropic client achieve the behavior a.	W		Even though Client #4 accomples tablished criteria, based retaining ability and level of rethe needs consistent trainings speech therapist request stabilization. However during the June 2 meeting the program will be received in activities as stated in reobjectives with staff assista supervision. However the stadocumenting the data wrongly an in-service training was recreational therapist on QMRP & HM will make sure obasis to check the proper documenting the attachment).	on his tardation, thereby ted for 2007 IPP vised. A various ecreation unce and aff were therefore done by 04/13/07, in weekly pentation.	6-11-07 4-13-07
	This CONDITION is Based on observation reviewed, failed to establish systems to monitoring and identification of the systems accordance with clief failed to ensure heart accordance with clief failed to ensure heart accordance with clief alled to ensure heart accordance with accorda	sure that specific health care into are met. s not met as evidenced by: on, interviews, and record ensure that direct care staff sencies policy and procedure all situations to medical 49]; the facility failed to o provide health care tify services that would rices were provided in ents needs [Refer to W331]; alth services were provided to the clients [W322]; failed to			Please see the answer to W 149, W 322, W 356 & W 393	W 331,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) ML A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
W 318	accordance with the schedule timely der failed to ensure it me performing glucose. The results of these the demonstrated fahealth care services 483.460(a)(3) PHYS	with nursing services in eir needs [W331]; failed to otal appointments [W356]; and let the requirements for monitoring testing [W393]. It is systemic practices results in ailure of the facility to provide it.	W 3			
	Based on observation review, the facility for preventive care for it the facility. (Client of The finding includes interviews with the bidirect care staff, me Director of Nursing (#5's medical records staff communication 2007 provided evided care staff failed to for health changes to the personnel as evidential interview with the March 20, 2007 at 1 March 11, 2007 betwife's health status chof vomiting and diameters.			An in-service training 04/13/07 for all direct emergency and non-emergency of DC Health Care	care staff in	4-13-07

		C INCOME OF TAMES				OMP NO	. 0938- 0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
DOHEA	LTH CARE				26 "Q" STREET, NW		
	CIII OAKE				VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(25) COMPLETION DATE
W 322	assistance with dreinis evening persona putting on his pajan bed. Although the HM do communication log client had vomited a care staff that he should be communication for concerns. Also that the medical/nursing client's change in he diarrhea and apparent he facility's non emitted policy, medical processes in activity. facility's policy was a march 11, 2007 as a personnel was not in health status. b) On March 20, 20 interviewed and reputational medical record of the his recliner chair. He to eat breakfast with was reported to nee feeding himself, had recliner by the HM. In the facility's communical record of the medical record of the medical record of the seasons.	ssing, had to be assisted with all care (taking a bath and has) and had to be assisted to be currented in the facility's during that evening that the and encouraged the direct could be watched, there was rom the overnight shift of any re was no documentation that staff was informed of the ealth status (vomiting, ent weakness) as required by ergency policy. According to be called for various a diarrhea, vomiting, sudden the HM confirmed that the not followed on the evening of the appropriate medical notified of the Client's change of the appropriate medical notified of the Client's change for two direct care staff were corted that on the morning of client was slow getting out of very weak as he needed as personal hygiene care. The her stated that the client had a living room where he sat in a living room where he sat in a living room where he sat in this peers. The client, who did minimal assistance with the beful his breakfast in his There was no documentation nunication log or the client's e client's continuing decrease	W	322	Please see answers on page 32 fe	or W 322	
		s also no evidence that the		ļ			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: 09G057			(X2) MU A. BUILL	LTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	
		B. WING		03/	03/22/2007	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 426 "Q" STREET, NW WASHINGTON, DC 20001		
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W 322	decrease in activite medical personne. c) Interview with the (LPN) on March 2: PM and review of physician's notes is staff informed the 6:45 AM that the cupset stomach that nurse and the nurdid not inform the diarrhea and vomit (March 11, 2007), the client's vital signadministered Pink evidenced that the appropriate medic Primary Care Physiobserved in the helpolicy.	by was reported to the facility's I as required by the policy. The facility's medication nurse 2, 2007 at approximately 4:00 the nursing progress notes and reported that the direct care nurse on March 12, 2007 at client was weak and had an at morning. According to the sing notes the direct care staff nurse of the client's had iting the previous evening. Although the nurse checked gns and his abdomen and Bismuth 30cc, there was not enurse contacted the all personnel (DON or the sician) concerning the changes walth of the client as required by	W 32	22		
	QMRP and review limited functioning and the decrease March 11 and Mar Reportedly he was made unfounded v	view with the staff, LPN, the v of his medical records the ability exhibited by Client #5's in his health status on both sch 12, 2007 was unusual. It is very talkative and usually verbally threats and would attention especially from the		An in-service training we direct care staff in rep changes and sudden decreases health status (See attach)	porting unusual	4-13-07
W 331	client had been ill o	ence prior to 3/11/07 that the or experienced vomiting eriods of weakness. NG SERVICES	W 33	1		
	The facility must preservices in accorda	rovide clients with nursing ance with their needs.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 331	Continued From pa	ge 34	W 331			
	Based on interview failed to provide ea in accordance with	s not met as evidenced by: and record review, the facility ch client with nursing services their needs for two of the eight ne facility. (Clients #3 and #5)				,
1	The finding include	s:			-	
	staff pertinent ques	edication nurse failed to ask etions to ascertain the client's complete a thorough V322]		Please see answers to W 322		
		rse failed to scheduled an etic appointment for Client #3.				
W 356	diagnosis of diabet client's annual physendocrinology appeas possible (ASAP) physician order dat revealed an order tendocrinology/diab the survey there was endocrinology cons	It's medical record revealed a set. Further review of the sical recommended that a bintment be scheduled as soon). Additional review of a sed November 28, 2006 to schedule and etic clinic ASAP. At the time of as no evidence that the sult had been scheduled. APREHENSIVE DENTAL	W 356	It is very hard to get an endoor appt. After various unsuccessful client # 3 has a endocrinology 06/15/07 @ 9.15 AM at team of DCHC make sure that done in proper time.	attempt appt. on Nursing	6-15-07
	treatment services needed for relief of	nsure comprehensive dental that include dental care paln and infections, , and maintenance of dental				
	This STANDARD	is not met as evidenced by:				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) h		IPLE CONSTRUCTION	(X3) DATE S	
09G057		B. WII			-		
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/2	22/2007
D C HEA	LTH CARE			4	26 "Q" STREET, NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		FROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IUI D RE	COMPLETION DATE
W 356	Based on observation review, the facility for appointments for two sample. (Clients #3) The findings include	on, staff interview, and record ailed to schedule timely dental to of the four clients in the 3 and #4).	w:	356			
	1. On March 20, 2007, Client #3 was observed with brown stains on his teeth. Record review of the dental consultation dated December 6, 2005 revealed that the client had "heavy calculus deposits, and an X Ray was taken." The dentist recommended that the client needed scaling and that they dental office would submit for authorization. There was no evidence that the recommended dental services had been performed in the a year and approximately three months. 2. On March 20, 2007, Client #4 was observed with stains on his teeth. Review of the clients				Client # 3 was seen by the dentist on 06/02/06 for scaling. Due to systemic problem with the dentist was not able to get a medical authorization program, thus resulting in receiving no services. Follow up was done on 11/22/06, where generalized scaling was done when recommendation return in six months. A follow up appointment was obtained for 05/07/07.		5-7-07
W 393	dated July 24, 2006 the client needs sca Interview with the Hothe client receives di "Medicald Waiver" p "major problem with dental office rectifies longer see "Medicald in September 2007. There was no evider dental services had it 483.460(n)(1) LABO If a facility chooses to	cuse Manager revealed that ental services under the rogram. The dentist stated, reimbursement. Until this the situation, we will not divalver patients. Call back that the recommended been performed. RATORY SERVICES	w 3	93	Client # 4 lives in an ICF/MR if an a medicaid waiver program - e with the dentist it was understood dentist might have it wrongly, classifying him in maiver. He also have a appointment for 05/07/07.	hecking ood that reported redicaid	5-7-07
_	the laboratory must i	neet the requirements					[

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2007 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Į.		IPLE CONSTRUCTION	(X3) DATE S	
			A. BU			OOM, L	ETED
14145 55 5		09G057	B. ***	· · ·		03/2	22/2007
	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 128 "Q" STREET, NW VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	DRE	COMPLETION DATE
W 393	Continued From pa specified in part 493		w;	393			
	Based on observation review, the facility facili	s not met as evidenced by: on, interview and record alled to ensure it met the rforming glucose monitoring ur clients in the sample.	•				
	2007 at approximate Client #3 has a diag medication nurse fur provides a urine sar glucose level. Additionally informed the survey tested for ketones a this process. The teclient's urine and are on the test bottle for medication nurse re	sedication nurse on March 20, ely 5:45 PM, revealed that mosis of diabetes. The other revealed that the client mple each morning to test his tionally, the medication nurse for that the client is urine is and the test strips are used for est strips are dipped in the ecompared with a color chart is comparative reading. The cords the glucose level on the			DCHC is in process to get a certification waver under CLIA. A fax was a send to CLIA office for requesting information about certificate. (Pleenclosed) We will secure CL 05/31/07	already g some ase see	Ongoing
W 436	Professional and an at approximately 12: provider did not hav required by part 493 Improvement Act (C 483.470(g)(2) SPAC The facility must furrand teach clients to choices about the us	ualified Mental Retardation d the Director March 22, 2007 30 p.m. revealed that the re a certificate of waiver as of the Clinical Laboratory LIA). E AND EQUIPMENT hish, maintain in good repair, use and to make informed se of dentures, eyeglasses, mmunications aids, braces.	W 4	36			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2007 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING	(X3) DATE COMP	
		09G057	B. WIN	(G		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 426 "Q" STREET, NW WASHINGTON, DC 20001		22/2007_
(X4) ID PREFIX TAG] (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 436	Continued From pa interdisciplinary tea	ige 37 m as needed by the client.	W 4	36		
	Based on observati review, the facility fa	s not met as evidenced by: ion, interview, and record ailed to effectively teach the em for one of the four clients ent #2)				
	observed pointing to direct care staff rep the bathroom. At approvas observed being The direct care staff thank you." Accord January 20, 2007, nowhich stated, "[the context to express a messa thank you for the same please) on three for three consecutive that during the entire observed using the device. 483.470(i)(1) EVAC The facility must hold quarterly for each start of the same please of the entire observed using the device. This STANDARD is Based on review of the bathroom is the same please of the	at 8:15 AM, Client #2 was bothe bathroom door. The lied, "Do you have to go the the client entered the eximately 4:35 PM, Client #2 offered an afternoon snack of stated to the client, "say ing to the client IPP dated evealed a program objective client] will use an AAC device ge (I'm going to the bathroom, ack, and will you dance with sof the four training sessions are months. It should be noted a survey, the client was never adaptive communication UATION DRILLS Id evacuation drills at least anift of personnel.	W 44	An in-service training 04/06/07 for all direct ensure proper impleme objective for Client #2.	Care otoff 4.	4-6-07

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE S	
		. 09G057	B. WING		03/2	2/2007
	ROVIDER OR SUPPLIER]	REET ADDRESS, CITY, STATE, ZIP CODE 426 "Q" STREET, NW WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
W 440	Continued From pa	ge 38	W 440			
	The finding include:	s:				
		lualified Mental Retardation rch 20, 2007, 2006 revealed are as follows:				
	PM - 6:30 AM Mond	; 2:30 PM - 10:30 PM; 10:30 fay through Friday and 6:30 PM - 10:30 PM; 10:30 PM - ind Sunday		,		
	failed to hold fire ev least quarterly. The conducted on the 2 Saturday or Sunday	rill log revealed that the facility acuation drills for all shifts at ere were five fire drills 30 PM -10:30 PM shift for The drills were conducted 12/4/06, 2/4/07, and 3/2/07.		All the direct care staff were in on 04/05/07 to ensure that fire held once a month in each shi will ensure that all the conducted and filed in the bothe regulations.	drills are ft. QMRP frills are	4-5-07
W 454	These above finding of the Fire Marshall 483.470(I)(1) INFEC		W 454			
	The facility must pro	ovide a sanitary environment d transmission of infections.				
	Based on observation facility failed to main	s not met as evidenced by: on and staff interview, the ntain a sanitary environment to ransmission of infection.				
	The finding includes	:			į	
	mouse was observe the living room under was further observe	at approximately 11:20 AM, a d to run from the kitchen into erneath a couch. The mouse d to stand on his hind legs ch and then proceeded to run		DC Health Care has a permanagement contract with Control In. The company prmonthly and on call visits.		·

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	I			OMB N	IO. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATI	E SURVEY PLETED
	·	09G057	B, WIN	IG_			
D C HEA	PROVIDER OR SUPPLIER			4.	REET ADORESS, CITY, STATE, ZIP CODE 26 "Q" STREET, NW VASHINGTON, DC 20001	03	122/2007
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OUR DRE	(X5) COMPLETION DATE
W 454	Interview with the fa Retardation Profess Assurance (QA) Co indicated that the pe standing monthly vis treatment of pest.	at couch to the opposite side order the another couch. acility's Qualified Mental sional (QMRP), Quality ordinator and the Director est control company had a sit to this group home for	W 4		DCHC has contract with Amer Control Inc. who service the fact routine basis. DC is infested with problem which is an ongoin However APC company was confacility was serviced again on (DCHC will continue to ser facility on routine basis and as	cilities on th rodent ng issue. alled and 05/01/07.	5-1-07
	company's treatmen	nce that the pest control It was effective in eliminating It ide a continuos sanitary					
					•		

DENTIFICATION N 09G057		CORRECTION (X1) PROVIDE ASSISTMENT (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 03/22/2007				
	ROVIDER OR SUPPLIER		I		TATE, ZIP CODE		1 03/	<u> 22/2007</u>		
D C HEA	LTH CARE		WASHING	TREET, NW TON, DC 20	001					
(X4) ID PREFIX TAG			LEACH DEFICIENCY MUST BE PRECEDED BY		VERI I	ID PREFIX TAG	PROVIDER'S PL (EACH CORRECTIV CROSS-REFERENCE DEF	VE ACTION SHO	ULD BE	(X5) COMPLETE DATE
1 000	INITIAL COMMEN	TS		1 000		· · · · · ·				
	#5) was conducted March 22, 2007. A clients was selected six clients with vary	and death investigate from March 20, 200 A random sample of defrom a client populing degrees of disallat was the designate survey.)7 through three lation of billties							
	This survey was ini survey, however, di incident manageme examine the Condit Treatment, Health (Protections.	tion of Participation i	e area of extended to in Active	·			·			
	The finding of this sobservations at the program, interview management, and a administrative recordincident reports on the state of the	group home and thr with direct care staff a review of the habili ds to include the un	ree day fand itation and				•			
	Note: On March 12 Health office was not death of Client #5 the 2007. The results of based on interviews Retardation Profess manager, two direct nursing staff (1 LPN (DON). In addition, habilitation records	otified via facsimile of nat occurred on Man of the investigation we with the Qualified National (QMRP), the his care support associand the Director of review of medical as	of the ch 12, vere fental come chates, Nursing		·	· ,				
1 092	3504.3 HOUSEKEE	PING		1 092						
	Each GHMRP shall and vermin.	be free of insects, re	odents							
th Regulat	ion Administration	01	/					<u> </u>		
RATORY	DIRECTOR'S OR PROVIDE	MLY Styl	/~~ TATIVE'S SIGNA	TURE	TITLE	Preside	of	(X6) DATE		

AND PLAN	INT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G057	ER/CLIA MBER:	A BUILD B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DBESS CITY	, STATE, ZIP CODE	03.	22/2007
D C HE	ALTH CARE	_	426 "Q" S	TREET, N STON, DC	W	_	·
(X4) ID PREFIX TAG	I (GACA DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	F-1 1 4	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	1 II B. 6-6	(XA) COMPLET DATE
I 092	This Statute is not Based on observation	met as evidenced by: on and interview, the as maintained free fro	CHARD	1092			
 ! 108		ncy Report Citation V	V454		Please see answer to W 454		
	Each GHMRP shall	assure that each resi	dent has propriate	I 108			
	This Statute is not me Based on observation GHMRP failed to proundergarments for outlier the sample. (Reside The finding includes: During the environme 21, 2007 at 3:40 PM, undergarments in his	n and staff interview, vide an adequate am ne of the three reside nt #1) ental inspection on Ma Resident #1 had two	arch		undergarments. Client # 1 som hides stuff from his dresser under behind the dresser as reported staff. QMRP will ensure that all	bed or by the	ongoing
	railed to provide addit Resident #1 use.	nsure survey, the factional undergarments	iiih.	ē	have atleast 7 pairs of clothing dresser all the time.	in the	
E	B505.5 FIRE SAFETY Each GHMRP shall co order to test the effect our (4) times a year fo	onduct simulated fire	eleille in	135			
Т	his Statute is not me	et as evidenced by:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 09G057		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
NAME O	F PROVIDER OR SUPPLIER	T 09G001	0700	j -		03	/22/2007
	EALTH CARE		426 "Q" STI WASHINGTO	REET. NV	STATE, ZIP CODE V		2301
(X4) ID PREFI TAG	A I LEAGH DEFAIRNES	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
l 13	Based on interview GHMRP falled to er	and record review, th	1 '	135			
	The finding includes	ll four times a year. s:			Please see answer to V	V 440 .	
l 18	See Federal Deficients 7 3508.5(d) ADMINIS Each GHMRP shall that shows the follow	TRATIVE SUPPORT		187			
	(d) The lines of auth This Statute is not n Based on staff interv Group Horne for Mei (GHMRP) failed to e delineation of author programmatic and ei	ority. met as evidenced by: riew and record review ntally Retarded Person nsure the accurate ity with regards to nvironmental responsi	nis			,	
2ne	authority and the cha organizational structu the proper assessme programmatic needs, maintenance/upkeep of the home. Record organizational chart fa changes, names and authority.	the facility's QMRP or revealed no clear line inges communicated in the regards to early of the resident's cand ensuring the of the physical environce review revealed the earlied to include position roles establish lines of the resident of the stablish lines of th	of n the nsuring are, nment	co po	rganizational chart was re rrected as of 04/01/07 sition changes. Names and lease see enclosed].	to include	04-01-07
1 206	3509.6 PERSONNEL Each employee, prior		J 20	6			

Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 09G057 B. WING NAME OF PROVIDER OR SUPPLIER 03/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 426 "Q" STREET, NW WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG COMPLETE DEFICIENCY) 1206 Continued From page 3 1206 annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on record review, the GHMRP feiled to have on file for review current health certificates for all employees annually. The finding includes: Review of the personnel files on March 20, 2007, Please see the attached the GHMRP failed to provide current health Health Certificate. certification for one direct care staff (TW), the Nutritionist. 1 222 3510.3 STAFF TRAINING 1222 There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report Citation W189 Please see answer to W189. 1374 3519.5 EMERGENCIES 1374 After medical services have been secured, each Health Regulation Administration STATE FORM

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	A BUILDIN	IPLE CONSTRUCTION	(X3) DATE S	APPROV SURVEY ETED
NAME OF	200110-1-1	09G057		B. WING_			
	PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY	STATE, ZIP CODE	03/2	22/2007
	LTH CARE		426 "Q" STE WASHINGT(REET NW	•		
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI		(X8) COMPLETE DATE
	no guardian, or the inspension as possible, for documentation no la after the incident. This Statute is not no Bassed on interview a	ptly notify the resident next of kin if the resident representative of the of the resident's stati llowed by written notic ter than forty-eight (4) the as evidenced by: and record review the sure notification of the	ent has lent has us as se and B) hours	374	DEFICIENCY		
1 401 3	- 1-0 and 14 134		1		lease see answer to W148, 7154.	W153, and	
P an de se	rofessional services nd evaluation, includ evelopmental levels	Shall include both air	gnosis	,			
Gi an res	sident's in the sample	of as evidenced by: If record review the Idea ongoing diagnos Idea for three of three Idea (Resident #3 and #					
1	e findings include: e Federal Deficiency 322	Report Citation W33	1,	Ple	ase see answer to W331 and	W322.	
Daamaii .	Administration			1		ľ	

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Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G057 NAME OF PROVIDER OR SUPPLIER 03/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 426 "Q" STREET, NW WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREFIX TAG (X5) COMPLETE TAG DATE 1421 Continued From page 5 1421 1421 3521.2 HABILITATION AND TRAINING . 1421 Each GHMRP shall provide habilitation and training to residents in the most normalizing environment and the least restrictive circumstances. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation and training for one of the four residents included in the sample. (Resident #1) The finding includes: Please see answer to W197 See Federal Deficiency Report - Citations W197 1423 3521.4 HABILITATION AND TRAINING 1.423 Each GHMRP shall monitor and review each resident 's Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by: Based on observation, staff interview and record review the Group Home for Mentally Retarded Person (GHMRP) failed to ensure the habilitation and skill building of residents as required by this section. [Residents #2, #3] The findings include: See Federal Deficiency Report citations W255 Please see answer to W255 and W263. and W263 Health Regulation Administration STATE FORM W8IP11

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Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G057 NAME OF PROVIDER OR SUPPLIER 03/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE D C HEALTH CARE 426 "Q" STREET, NW WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETE DATE TAG TAG DEFICIENCY) 1 424 Continued From page 6 1424 1 424 3521.5(a) HABILITATION AND TRAINING 1424 Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan: This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure program revisions were made at least every six months or when a resident successfully completed the objective. The finding includes: (See Federal Deficiency Report-Citation W255) Please see answer to W 255. 1 427 3521.5(d) HABILITATION AND TRAINING 1427 Each GHMRP shall make modifications to the resident 's program at least every six (6) months or when the client (d) is being considered for training toward a new objective or objectives; or... This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure modifications were made to the residents individual program plan in conjunction with the Individual Support Plan meeting. The findings include: See Federal Deficiency Report Citation W255 Please see answer to W 255. Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G057 03/22/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 426 "Q" STREET, NW D C HEALTH CARE WASHINGTON, DC 20001 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 3521.7(g) HABILITATION AND TRAINING 1437 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to implement Speech and Language objective as outlined in the annual assessment for one of the four residents in the sample. (Resident #1 and #3) The finding includes: Please see answer to W 227. See Federal Deficiency Report - Citation W227 1 458 3521.11 HABILITATION AND TRAINING 1.458 Each resident 's activity schedule shall be available to direct care staff and be carried out daily. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's activity schedule was carried out daily The finding includes: (See Federal Deficiency Report - Citations W197 Please see answer to W197. and W250) and W250 Health Regulation Administration